

STANDARD CERTIFICATE OF DEATH

State File No. **33209**

FILED OCT 4 1952

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8804**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY OR TOWN St. Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis - Mo 2107	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Pacific Hospital		d. STREET ADDRESS (If rural, give location) 4466 Elm Bank Ave	
3. NAME OF DECEASED (Type or Print) MRS. Catherine - Maginness		4. DATE OF DEATH (Month) (Day) (Year) Sept-19-1952	
5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARCH 4-1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Ireland
12. CITIZEN OF WHAT COUNTRY? Irish		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Thomas Maginness	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT'S SIGNATURE OR NAME Thomas Maginness		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CHRONIC Myocarditis ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute Cardiac Decompensation DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION NONE		19b. MAJOR FINDINGS OF OPERATION NO OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) NONE		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 4222		22. I hereby certify that I attended the deceased from Sept 14, 1952 to Sept 19, 1952 that I last saw the deceased alive on Sept 19, 1952 and that death occurred at 4:30 P.M. , from the causes and on the date stated above.	
23a. SIGNATURE (Deceased or title) Joseph A. Lembeck M.D.		23b. ADDRESS 607 N. Grand Blvd	
23c. DATE SIGNED 9-20-52		24a. BURIAL, CREMATION, REMOVAL (Specify) 9/22/52	
24b. DATE 9/22/52		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Mo		25. FUNERAL DIRECTOR'S SIGNATURE Harold Carroll	
DATE REC'D BY LOCAL REG. SEP 20 1952		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	
25. FUNERAL DIRECTOR'S ADDRESS 4600 ...		G.P. (Licensed Embalmer's Statement on Reverse Side)	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Albert Mappfield

Licensed Embalmer No. *3097*

P. O. Address *ST LOUIS MO*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.